DO WE NEED TO KNOW WHAT WE ARE DOING?

Discovering our "working model" of psychoanalytic practice using the Comparative Clinical Method

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In my experience many psychoanalytic practitioners, both students and experienced therapists, have an ambivalent attitude towards psychoanalytic theory and intellectual knowledge for understanding and developing their clinical practice. Analysts and therapists frequently express their wish to know more theory, or better understand the theories they use. But a more distrustful attitude towards theory and theorizing is also often expressed, one that sees too much interest in or reliance on theory and wanting to know as an obstacle to good clinical practice. This view is often attributed to Bion, in his well-known recommendation that psychoanalysts need to develop the "discipline" of abstaining from memory, desire and knowledge: "the capacity to forget, the ability to eschew desire and understanding, must be regarded as essential discipline for the psychoanalyst" (Bion, 1970, pp. 51-2). The problem with this much quoted idea is that it presumes a very high level of clinical development and sophistication in order to be put into practice. One cannot abstain from something, at least in a disciplined way, unless

one is already deeply familiar with the something from which one is trying abstain. If we take Bion's use of the terms memory, desire and understanding as a way of describing the basic theoretical framework that we habitual use in our clinical work – understanding referring to theory, memory to the links we habitually make using our theoretical ideas, and desire as the aims of our clinical work and our ideas on what constitutes psychic change – we first of all need to know what this framework looks like and how we use it before we can attempt to give it up. However it is actually very difficult to try to get hold of our own particular framework, as once we have internalized our own way of working it becomes something we normally use without explicit thinking – as Winnicott put it, "the only companion that I have in exploring the unknown territory of the new case is the theory that I carry around with me and that has become part of me and that I do not even have to think about in a deliberate way" (Winnicott, 1971, p.6)

Having one's theoretical framework so deeply embedded that it becomes part of oneself is essential for our normal way of working, as it means it can function silently in the background and not get in the way of our listening to the peculiarities and unique features of each patient. In more formal supervision and clinical presentations it becomes important to try to extract this theorizing , so as to subject it to critical thinking and enquiry. And if one is to try to establish some kind of more general enquiry into the way psychoanalytic clinicians actually work it becomes essential to find a coherent and systematic way of describing the particular theoretical frameworks that are actually used in analytic practice.

One reason for these different attitudes towards theory in psychoanalytic practice comes, I think, from a confusion as to what is actually meant by "theory". What we learn in our psychoanalytic trainings is theory at a very general and abstract level. Theoretical frameworks and concepts need to be pitched at this level in order to be widely applicable to a range of different sorts of patients and to encompass different sorts of clinical situations. In this sense, it makes sense to think of the need to abstain from an over-reliance on theory, as these very general ideas may not be specific enough to be of value in understanding any particular clinical situation, just as a good cook learns to play around with a given recipe in order to create his or her own distinctive dishes. But theory in psychoanalytic work can be used in another sense, more like the idea of having a theory that one carries around with one, a constant companion for making sense of any clinical situation. Theory in this sense consists of a network of more implicit and specific ideas, guiding assumptions, protocols, models, conceptual frameworks etc., which inform our clinical work at a much lower level of abstraction than the more general theory we have learnt. A Working Party on Theoretical Issues set up by the European Federation of Psychoanalysis in 2003 to investigate the way psychoanalysts use theory came up with the idea of "implicit theory" or "intermediary theoretical segments", to designate these kinds of low level and more personal theories we rely on in our everyday work (Canestri, 2006). These kinds of theories normally operate at a preconscious or tacit level. This means that when we try to apply theories at a more explicit and discursive level, as a body of relatively coherent and clear ideas, we may not be accurately describing the kind of theorizing we actually do in our everyday analytic work – "analysts do not do what they say (and believe) they do" (Canestri, 2012, p.157).

The work of the Clinical Comparative Methods Group

In this paper I want to look at the work of another Working Group set up by the European Federation of Psychoanalysis in 2003, called the Working Party on Comparative Clinical Methods. Their task was to find a way of describing and then comparing the different methods used by psychoanalysts in their work. Their way of going about this task was to invite a number of senior and experienced psychoanalysts to present their clinical work in small groups in sufficient detail for their implicit working method and use of theory to become available for discussion. In their account of what happened, the organizers of this Working Party describe how their expectations and hopes for this project had to be changed (Tuckett, 2008).. They started off by assuming that despite their differences, the psychoanalysts participating in the project would have enough of a common and agreed language in order to engage in a fruitful and productive clinical discussion. They discovered that this common language did exist, but not where they expected to find it. What they found was that, in their accounts of their own work and in their group discussions of the work of other analysts, the participants in the workshops used the same psychoanalytic concepts in different ways, and to mean different things. For instance, most if not all the analysts claimed to be working in or with the transference and to be making transference interpretations. However, when it came to getting to the specificity of these transference interpretations, that is what each analyst actually meant by "making a transference interpretation", what it would look like, what its function was and so on, then there was often disagreement if not conflict about what actually could count as a

"transference interpretation". Furthermore these discussion often took a prescriptive tone, the discussion becoming not what we mean by a transference interpretation, but a declaration of what it should be, that is what is to count as a "proper" transference interpretation. The authors describe how this seemingly unstoppable process in clinical discussions to establish the right form of psychoanalysis - that is whether the particular presenter was, in fact, working psychoanalytically or not, which meant that what was meant to be a clinical discussion between colleagues turned into a subtle or indirect form of one analyst supervising another – threatened to derail the whole working project.

In order to get the working group back on track, the authors describe how they had to do two things. Firstly in order to create a productive and effective working group of analysts, the organizers instigated a basic rule of conduct in each clinical workshop: that the presenter should be treated by each member of the group as if he or she were a competent psychoanalyst. So, for instance, when faced by the presenter describing a way of working that one might think was not very good, and indeed perhaps not really "psychoanalytic", the task of each member of the group was not to give in to or indulge this supervising and critical impulse, but to start from this assumption: that each particular way of working does have a psychoanalytic logic of its own, it does form part of a coherent working model of the presenter, even if it is not apparent what this logic is. The aim, then, was to find a method which could reveal what this implicit logic might be.

This was the second task of the Working Group: to create a conceptual framework or comparative tool that would enable the participants in the clinical workshops to describe

each presenter's particular way of working. The usual psychoanalytic vocabulary was sometimes found to be compromised, as the group members were using the same language to mean different things. The organizers also found that many psychoanalysts were often so strongly wedded to their own psychoanalytic vocabulary that they were unwilling or unable to put it to one side so as to be able to incorporate different ways of thinking. So in putting together a framework or model which the group members could use, the organizers of the Working Party had to fashion their own language to describe the make-up of each analyst's working theoretical framework or model of psychoanalysis. For instance, the organizers chose to use the term "intervention" rather than "interpretation" to describe each discrete instance of when the analyst spoke or acted in such a way as to communicate something to the patient. This was done in order to create a conceptual language which had sufficient generality to describe the whole range of ways in which analysts speak to their patients. Furthermore a word such as "intervention" could be seen as more neutral than "interpretation", not implying some forms of interventions are better than others. It is here, I think, that the organizers of the Working Party found their common language: that there was sufficient "common ground" between the analysts in the Working Party to create and use a conceptual tool with which to describe and then compare the different ways of working. But this common language could not be assumed from the start. It had to be discovered, and indeed would be more likely to emerge only when a group worked hard together to tease out its various basic assumptions about the psychoanalytic method.

The "two-step model"

Over a number of years of meeting together, the organizers devised a more systematic way for the clinical discussions to be conducted, one which would be more likely to capture the "working model" that informs the way each of us does our analytic work. In each small group clinical workshop the presenting analyst was asked to describe two consecutive sessions in great detail, paying particular attention to describing as accurately as possible each intervention made by the analyst. The participants in each of these clinical groups were given a very specific task, which was to implement what the organizers came to call the "two-step model". In the first step of the model, the group members were asked to describe the function of each of the analyst's interventions. In order to facilitate this task, the model allowed for each intervention to be assigned to one of five different categories. These categories were as follows: 1) maintaining the basic setting; 2) interventions designed to facilitate unconscious communication; 3) clarifying, through questions or re-formulations what the patient was saying (to facilitate more conscious thinking); 4) addressing the analytic situation (addressing the transference); 5) making a construction as a form of elaborated meaning. The organizers added a sixth category, in which the analyst did something they recognized as a mistake or enactment.

Once this more descriptive task had been accomplished, in the second stage of the model the participants are asked to try to construct, from the description of the purpose of each intervention, the different elements of the presenting analyst's clinical "working model". This working model was broken down into five constituent elements, which could be addressed by group members trying to find an answer to these questions concerning the

presenting analyst's implicit theorizing: 1) what does the analyst think is wrong with the patient (implicit theory of psychopathology)? 2) how does the analyst listen to the unconscious (listening priority)? 3) what is the presenting analyst's implicit theory of change? 4) how does the presenting analyst further the analytic process (i.e. what the analyst does to implement their theory of change)? and 5) what is their understanding of the analytic situation (their theory of transference)? (The two-step model is described in Tuckett, 2008, pp.136 and 164; as the model is continuously revised, a more up to date version can be found on the current Comparative Clinical Method Association website, https://sites.google.com/site/ccmethods/home. In my descriptions of the model I will be using its current version as was made available to me in 2018).

This may look like a very intellectual process, too far removed from the emotional drama and experiential feel of listening to an analyst describe a session, and in a way it is. Its value is that instead of keeping an artificial split between intellect, emotion and experience, it invites group members to use their intellectual in an imaginative and disciplined way to think deeply about the emotional experience of the analytic work described by the presenting analyst. It is made clear to the participants that the point of using this model is not to come to a "right" answer, nor, indeed, for the group to agree with each other. Disagreement is prized, as it opens the group members up to take account of different points of view. The aim of the method is to generate the kind of creative and productive discussion that is necessary in order to do justice not only to the

fact that this working model has to be extracted from the session material, but also to the complexity of this working model .

My understanding of how this two-step model works in practice is partly based on my careful reading of the account given by the organizers in their book (Tuckett, 2008), and also on my own attempts to incorporate this model into my own thinking and practice (Spurling , 2015). However this understanding was not based on any experience of using the model. In 2017 and 2018 I attended two conferences organized by the Comparative Clinical Methods Association (the successor to the initial Working Group which had a 10 year life span), in each of which I was a member of one of these moderated small group clinical workshops, and it is on this experience that I can claim to have some basic knowledge of the method. On each occasion the workshops consisted of between 10 and 12 psychoanalysts, with one presenter, who gave us a written account of two sessions, and who then did not take part in the subsequent clinical discussion except to answer questions or make clarifications. Each clinical workshop was facilitated by one or two moderators, who were there to ensure the group stuck to its task, as well as to record the group discussion and the outcome of the group task in order for the Comparative Clinical Methods Association as a whole to further its task of describing and comparing the different kinds of working models employed in psychoanalysis. The clinical workshops (there were four in each of the two conferences I attended) met four times, over a period of one full and two half days, for a period of about 12 hours in total.

I found the work in each workshop to be highly concentrated, intense, stimulating and engrossing. In some ways it was similar to any other form of clinical discussion in which a clinician is prepared to be open about the personal and intimate nature of their work, and where the group members are also able to engage in a productive and open way with the presenter and with each other. However what was distinctive about being part of this type of working group was that I found it much more challenging, at times frustratingly so, compared to being in a more usual type of clinical discussion. On many occasions we needed to be reminded by the moderators to keep to the discipline of exploring what we thought the *analyst* was doing, what was his or her working model, whereas the tendency for all of us in the group was to talk about our understanding of the *patient*, how we understood the patient's difficulties, and how we thought this influenced if not determined what we thought the analyst was doing. Of course it is impossible to understand the analyst and his or her interventions and overall strategy without also understanding the patient as the other half of the analytic dyad. But what this kind of workshop makes clear, in my view, is that whereas in psychoanalysis as a whole we now have highly developed and sophisticated ways of describing and understanding different types patients, and how they affect our work, we are much more at sea when it comes to describing different types of analysts and how they conduct an analysis. We are very good at construing what the analyst might be doing or thinking *as a consequence to or reaction to* what we understand the patient to be doing. But we are far less able to think of the analyst as having a working model or theoretical framework in its own right, which informs the way his or her analytic work is actually carried out (Jimenez, 2009).

This was evident from the difficulties I and my fellow participants experienced in each group in trying to address the questions posed to us by the two step model. For instance, in step 1 of the model, when our task was to describe each of the presenting analyst's interventions by assigning it to a particular category, I noticed that many times the members of the group could not decide whether to see a particular intervention as an example of "adding an element to facilitate unconscious process" (the second category), or of the third category, an instance of "questions, clarifications, reformulations aimed at making matters conscious". In order to make this discrimination, we had to come to some agreement about where we thought the intervention was primarily aimed (primarily, as most interventions made by competent analysts have multiple aims). If we thought the analyst was implicitly aiming to stimulate the patient's unconscious process, then we would assign the intervention to category 2. But if we thought the aim was more to support, strengthen or initiate the patient's capacity to think more consciously, then we would decide the intervention belonged to category 3. The model forced us to come down on one side or other of this fence. The value of doing this, something which felt counter to our normal analytic tendency to work productively with ambiguity and overdetermination of meaning, became clear later, when we started to construct the main elements of the presenting analyst's working model. Assigning each intervention to a particular category enabled us to see what kinds of interventions were used most. If an analyst tends to use more category 3 interventions, aiming at clarification and more conscious thinking, he or she is likely to believe that insight and understanding is more

likely to be achieved by making more saturated interventions. By contrast an analyst making use of more unsaturated interventions, such as the more allusive types of interventions assigned to category 2, may well have an idea that insight is best achieved in more indirect ways. This may also mean that such an analyst will have a different understanding of insight, or perhaps give it less weight than an analyst who makes more use of category 3 interventions.

Attempting to construct the presenting analyst's working model, step 2 of the model, did not prove to be any easier than step 1, describing the interventions, as the group members struggled continuously with trying to differentiate between different aims and methods which are part of each analyst's working model. For instance, one part of the analyst's working model is the particular way we think the analyst listens to the patient's unconscious. We were asked to consider this by addressing three different aspects of this listening. Firstly whether the presenting analyst is using a more "evenly suspended/hovering attention" or a more "conversational style". Secondly, what "mode of listening" is predominantly employed: using observation, empathy ("sensing the patient's experience"), whether the listening is more "subjective" (using the analyst's subjective responses), and/or "intersubjective" (watching the effect of patient and analyst on each other)? Finally what content does the analyst listen out for: emotions, resistances, conscious meanings and parallels, or opportunities for translation of meaning? In my group each of these questions provoked vigorous discussion as we struggled not simply to make sense of the differences, but to find evidence in the analyst's actual interventions. At first it seemed the presenting analyst was doing all of

these. But when we were pressed by the moderators to make a decision, we had to work harder, and in so doing were able to come up with hypotheses that started to give a clearer picture of how we thought the particular analyst was listening to the patient. In so doing, in being able as a group to argue for different and sometimes competing ways of understanding what we thought the analyst was doing, we were able to conceptualize to ourselves a wide range of different interventions, strategies and techniques within which to try make sense of the particular way of working of the presenting analyst. This expansion and enrichment of our clinical repertoire, and the underlying rationale for each clinical intervention was, I think, one of the main learning experiences of the workshops.

The experience of participating in these clinical workshops also confirmed for me something I already suspected, that the implicit working model of any competent and experienced practitioner is likely to be complex and multi-layered. In fact the work of trying to construct a particular analyst's working model raises for me further interesting and complex questions. For instance, how coherent or internally consistent does a working model of psychoanalysis have to be? Is there room in a viable working model for elements that do not cohere, or might even be in conflict with each other? And if examples of such inconsistencies were found, how could we tell the difference between seeing this as a sign of maturity, an ability to tolerate ambiguity and even conflict in one's basic approach, or as a sign of a failure to bring together different or competing ideas into a viable whole?

Illustrating the use of the two step model

As with any model or method, particularly if it is quite complex, one can only really get a sense of its purpose and value by seeing how it works in practice. I cannot speak of the cases presented in the working groups I attended at the Comparative Clinical Method conferences, nor of the group processes I experienced (except in the most general sense) for reasons of confidentiality. So I have chosen instead to illustrate my own understanding of the model, bearing in mind I am still in the process of learning the model myself, by taking a published example of a case presentation in order to show what I take to be distinctive about this approach. The Comparative Clinical Method is not designed for a lone commentator on a piece of published material, the presence of the group is necessary for ideas to be elaborated and tested, as is the involvement of the presenting analyst, who can comment on the speculations made about his or her thinking. Nevertheless I think the method can still pose interesting and fruitful questions about any piece of clinical work.

I have chosen some clinical material published in the "British Journal of Psychotherapy" as part of their "Clinical Commentary" section (Clinical Commentary 39, 2018, pp. 179-193). The clinical material was written anonymously, and was sent to three commentators, who each wrote an account of their understanding of the case. The presented case is complex, raising a number of interesting clinical and theoretical issues, and each of the clinical commentators put together a sophisticated argument about what they understood to be the main features of the clinical account. For reasons of space I

can only offer a highly condensed account of the case and address small pieces of the work presented.

The case concerns the once weekly psychoanalytic psychotherapy of a 32 year old man, who has been coming to therapy for 18 months. He came with a number of obsessive and compulsive symptoms, for instance persistent and intrusive thoughts that his girl friend was being sexually unfaithful. There is an account of his background, one salient feature of which is that he never knew his father and was felt to be his mother's "savior". There is also an account of the progress of the therapy so far in which the therapist speaks of his/her countertransference fear in the early days of treatment "that the magnitude of his rage would lead him to attack his girlfriend and I took exceptional care not to say anything that might be construed as indulging his fantasy of her promiscuity" (Clinical Commentary, 2018, p. 180). This is followed by a detailed description of one session.

In the session the patient speaks of the pressure he feels under with his girl friend asking him when they can have a baby, and of other relationships in which he says he would be unable to believe that either party could remain sexually faithful. In describing his work, the therapist powerfully conveys how helpless he/she feels in the face of the patient's despair and hopelessness in overcoming or just managing his debilitating symptoms. The therapist ends his/her account on this note: "I have a growing sense of crisis, as Brooke [the patient's girlfriend] presses for her decision, but I feel utterly stuck, as stuck as he does, bearing witness to his cruel self-persecution" (p.183).

The three commentators give their own understanding of the clinical dilemma so vividly described by the writer. The first, Anne Worthington, writing from a Lacanian perspective, focuses on the question of diagnosis as a basis for deciding how to proceed, looking in particular at how a Lacanian understanding of obsessionality can point to a way of working (minimizing the (m)Other's desire). The second, Rowena Deletant, writing from a Jungian perspective, turns her attention to the way she imagines the patient has become trapped in a kind of claustrum and how she thinks the therapist's approach is to try to tease open some potential space in his mind and in the therapeutic relationship. The third commentary, by Stanley Ruszczynski, offering the perspective of a psychoanalyst from the British Psychoanalytic Association, looks in particular at the unresolved oedipal situation of the patient, and how the patient's self-persecution and impotence is projected into the therapist, leading him/her to offer "well-meaning reassurances" (as the patient's parents did) and to then feel stuck. I found each of these commentaries illuminating in offering different perspectives on how to understand the particular patient described and how this understanding of the patient's history and state of mind affected the therapist and throws light on what the therapist was trying to do. It was clear that in each commentary the understanding offered was the outcome of what the editor of the series, Ann Scott, describes as the commentator's "deep engagement with the material" (p.177).

Approaching the clinical material from a perspective based on the two step method of the Comparative Clinical Method, another form of deep engagement would be required, one that paid less attention to the patient and much more to the approach of the analyst. The

question addressed by the commentators could be posed as: can we offer a different perspective on the patient, and the nature of the therapeutic interaction? In so doing, the commentators would be bound to address aspects of the patient's psychopathology and interaction with the therapist which, in their view, had been missed out or not sufficiently appreciated by the presenting therapist.

Approaching this clinical material from the perspective of the two step model, I would be asking different sorts of questions. My main question would be: how is this therapist working? I would first of all look at every intervention described, (step 1) and ask myself: what do I think the therapist is trying to do here? What is the function of this particular intervention? In so doing, I would make the assumption that there is an intrinsic logic to each utterance. Having done that, I would then try to construct, based on my description of these interventions, the therapist's working model (step 2). In so doing I would be much less interested in what the therapist *does not do* (although it is always interesting to consider any intervention in the light of other possibilities), nor what I think of what he or she *should be doing* (although such critical thinking, if delivered in a constructive way, can be of great value). My frame of reference would be what I think this therapist *is actually doing.*

Describing the interventions

The first step is to describe each intervention made by the therapist. I counted 10, consisting of nine verbal interventions, and one action, that of letting down the blinds which the therapist does at the start of the session. Some are quite short, such as the

second intervention "I wonder if it is that Brooke [his girlfriend] wants *a* baby or *your* baby" (p.181), or the 9th and 10th interventions, which follow the patient saying he has been on the website to learn about how to cope with jealousy about your partner's past:

> I say "But it doesn't help'. 'No'. 'Because you cannot stop persecuting yourself. In all this, you are tormenting yourself' (p.183).

There is one long intervention, the 8th, in which the therapist suggests to the patient that there are two Brookes, the first the Brooke he wants to live with and have a baby with, and a second Brooke "who is in his head, promiscuous and mocking and with whom he is furious" (p.182). The therapist goes on to say that the patient wants to get rid of this second Brooke by abandoning the first, but if he stays with Brooke then the second Brooke would be with him forever.

In my experience in the clinical workshops, interventions that at first sight seem relatively straight forward to describe sometimes turn out to be quite contentious. Take the first intervention, that of closing the blinds. This action by the therapist is based on his account of how the session begins.

> 'Can we close the blinds, please?' The nights are drawing in now, the lamps are on low in the consulting room and though there is vanishingly little chance of being seen, Theo [the patient] feels exposed (p.179).

The most obvious way of describing the purpose of this intervention would be to see it as an example of "maintaining the basic setting" (category one). But in a clinical workshop it is likely that some members of the group might be worried by this intervention, seeing it as the therapist already in the grip of some form of enactment, of dispersing the patient's anxiety rather than analyzing it, or perhaps trying to be an over protective mother. So a case might be made for seeing this intervention as an enactment (category six), which is described as a "sudden and apparently glaring reaction not easy to relate to the analyst's normal method". But the problem here is that there is no evidence that the therapist does see this intervention as a mistake or enactment. On the contrary it is clear that he sees his intervention as an important or even necessary part of his way of working, namely creating a frame in which his patient feels safe enough to work.

The long 8th intervention with the two Brookes seems best assigned to the (5th) category of "constructions, directed at providing elaborated meaning". But most of the therapist's interventions seem to me to be more open to debate as to how best to understand their purpose and function. For instance the 5th and 6th interventions follow the patient speaking of watching a TV programme about his favourite body builder:

> He's just moved to LA with his wife. I thought, 'You lucky So-and-So!'. I'd love to move to LA. Then I looked at her, his wife, and thought, 'I wonder if she's had other men? (p.182)

The therapist says:

> "Almost certainly. And if you left Brooke virtually every other woman you met would also have a past too". I add, echoing something he has said before, 'And if by chance she did not, you would start at once thinking she was bound to want to have someone else' (p.182).

How can we best describe these interventions? Are they constructions, directed at providing elaborated meaning? Or are they better described as interventions that consist of "questions, clarifications, reformulations aimed at making matters conscious" (category 3). This seems to describe the form of this intervention, which is a kind of clarification or reformulation of what the patient has said. But what about category 2, that is interventions which "add an element to facilitate unconscious process"? Probably not, as these are described as "likely to be ambiguous, polysemic and brief", aiming to encourage association or linking at an unconscious level. But maybe this is not so clear. These two interventions could perhaps be seen as not so much reformulations or clarifications but as having something provocative about them, designed to stimulate more unconscious process on the patient's part. The therapist could be seen as implicitly pushing the logic of the patient's thinking further to its extreme, with the aim of demonstrating to the patient the absurdity and madness of his thinking. He does not do this in an explicit way by making a saturated clarification (category 3) or interpretation (perhaps category 5), but in a more indirect way, by depicting a scenario in which the patient might catch a glimpse of the absurdity of his own thinking.

There is something else interesting about the form of these interventions, in which one is described as an addition to the first (or perhaps this is better seen as one intervention in two parts?). How might we understand this? Is it perhaps implicitly designed to give the patient the experience of being with someone capable of non-obsessional thinking, in which the therapist can play around with his or her ideas, use one idea as a building block for another idea? Or, as the addition seems to repeat in intensified form the previous intervention, is there an implicit idea that the best way to get through to this patient is by persistently keeping to the same theme of the damage the patient is doing to himself (as seems to be the case with interventions 8 and 9 as well)?

The same questions could be considered in relation to the therapist's second intervention, "I wonder if it is that Brooke wants *a* baby or *your* baby" (p.181), in which the form is of a clarification or reformulation, and so appealing to the patient's more conscious understanding, but it could also be seen as more designed, by the pointed juxtaposition of "*a* baby" and "*your* baby", to stimulate more unconscious processes in the patient.

In the second step of the model, the task is to try to construct the presenter's working model of psychoanalytic practice. A key aspect of this, provoking much debate in the clinical workshops I took part in, was in considering two aspects of this working model: what is the presenter's view of "how analysis works" (i.e. what is their implicit theory of psychic change) and how do they "further the analytic process", that is "what it is the analyst actually says and does in order to bring about change according to their implicit theory of change"? One of the most interesting questions concerning psychic change is

"Does the theory about change involve a different or new object and of what sort?" A further question, about how the analyst furthers the analytic process, is "How does the analyst create a new object in the sessions?" In attempting to answer these questions in the clinical workshops, we all agreed that all psychoanalytic clinicians aim to create a new object. Simply giving the patient an experience of being with someone different to their original object already does this – otherwise the analysis would simply repeat the original trauma or failure. However we could also see that we can differentiate between those ways of working in which the creation of a new object could be seen as present but not in the forefront of the analyst's thinking, and those in which it is. Based on the interventions I have described, as well as some of the comments made by the therapist, I would think the creation of a new object is an important part of this therapist's theory of change. Closing the blinds so as the patient does not feel too exposed, and directly replying to the patient's obsessive questioning "I wonder if she's had other men?" in the 5th intervention described above (which begins "almost certainly") could both be seen as evidence of the therapist trying to create a new object, a more sensitive, responsive and empathic one. There might be more evidence for this in considering how the therapist listens to the patient's unconscious. The form of listening is clearly more conversational than one of evenly suspended attention, and it seems to me to be more empathic and subjective rather than observational.

My answer to the question ""how does the analyst create a new object in the session?" would focus on the therapist's description of him/herself as "bearing witness" ("I have a growing sense of crisis, as Brooke presses for her decision, but I feel utterly stuck, as

stuck as he does, bearing witness to his cruel persecution", p. 183). This idea of bearing witness seems to me to describe the purpose of many of the interventions described, in which the therapist seems to place himself or herself alongside the patient. So the theory of change would seem to be one in which the therapist needs to undergo experiences similar to the patient in order to understand them and thereby put them into words. If this is correct, it may throw some light on a remarkable feature of this presentation, which is that, when delivering the long construction about the two Brookes (intervention 8) the therapist describes himself as losing faith in what he is saying: "Even as I say this, I feel I am getting nowhere. I know he knows all this, though perhaps not in these words. And I know it counts for nothing" (p.182). Perhaps there is an idea here that the therapist needs to go through a similar experience of self-doubt himself before he can help the patient. Or perhaps the idea is that it is in this very process of going through a similar experience to the patient that the patient will be changed.

Another way of thinking of the therapist's reaction to his own construction is that it could be seen as the therapist trying to evaluate his own way of working. Perhaps he feels he is relying too much on making constructions or clarifications, appealing to the patient's more conscious thinking, and that this is going nowhere. So although the therapist declares himself stuck, it may be that in this session we are seeing some evidence of the therapist trying to unstick himself. We might then wonder what this therapist's theory of stuckness or *impasse* might be: how he understands it, and what he does to get himself over or past it. For example might his losing faith in the value of what he is saying be seen as a first step towards putting himself in the position recommended by Bion, of

eschewing memory, desire and knowledge, which is one way of approaching a clinical situation in which one comes to the sorry conclusion that one's current way of understanding the patient is not working?

Here we can see the value of looking at the next session or further sessions to see whether the therapist remains stuck, or whether we can see examples of how he tries and perhaps manages to move forward. The temptation in considering the therapist's stuckness is for us to try to explain *why* he is stuck, what he is missing or failing to take into account or enacting in his work. The Comparative Clinical Method keeps our attention on how the therapist understands or theorizes his stuckness, which will make sense of what he tries to do with it.

In taking these few examples of both steps of the model, there is much I have had to miss out. Perhaps the most notable omission is any consideration of the therapist's understanding of the analytic situation, or his theory of transference. The therapist makes one reference to transference in his account – "in the transference, I fear I am like his mother, and like the websites, well meaning but unable to make the smallest dent in the fury that rages inside him and will not leave him alone" (p.183). None of the interventions he makes would seem to fit the category of transference interpretation (described as "designating here and now emotional and phantasy meaning of the situation with the analyst"). There is much to think about here. In the one short sentence of his understanding of the transference, it looks like he is thinking of transference as a form of repetition in which he is trapped. It is very hard to extract a theory of transference from

this (which is described as "how the analyst supposes the patient's infantile past comes into the present in the session and how the analyst comes to know this"). Is this how the therapist normally thinks of transference, or is he here describing something different, a kind of transference enactment? Might this be why, in this session, there are no examples of transference interpretations – the therapist may think he needs to free himself from the transference in order to understand it and then speak of it. It may also be that the therapist does not consider making this type of intervention would be effective with this patient at this stage of the therapy. One of the questions in the model, concerning the analyst's theory of psychic change, is "does the theory include an idea that patients may have difficulties taking in interpretations?". I think this describes what the therapist is trying to do in this session, to find a way of getting through to the patient, to circumvent the patient's rigid obsessional thinking, which he does by a mixture of clarifying remarks, and some more designed to stimulate unconscious processes in the patient.

My purpose in these speculations is simply to illustrate how the model works, the way it approaches any clinical material and the kinds of questions and puzzles it generates. I have not been able to come up with any simple description of this therapist's working model, which may be due to the limitations of the task I have set myself, and to do with my own relative lack of experience of applying the model. But this may also be a feature of using the model itself. On both occasions when I participated in the clinical workshops it was the process of using the model, rather than the outcome in terms of a neat description of the analyst's working model, that generated the learning and the enjoyment of using the method.

Adapting the two-step model for psychoanalytic psychotherapists

There is another reason I have found the Comparative Clinical Method so interesting and resonant, which is that it helps me think of my own professional and clinical identity, which is not that of a psychoanalyst but a psychoanalytic psychotherapist. The method was designed by psychoanalysts for psychoanalysts. It was not meant to be directly applicable to psychoanalytic psychotherapy. In fact at the two conferences I attended, as far as I know, I was the only person there who was not a psychoanalyst. I found this to be no obstacle at all to being able to fully participate in the clinical workshops. I have also found the model to be directly applicable to my own clinical work as a psychoanalytic psychotherapist, and to my supervision, teaching and the way I run clinical seminars (Spurling, 2015). Furthermore , in this instance, I have applied the model directly and without adaptation to a piece of once weekly psychoanalytic psychotherapy.

I think where there are major changes to the aims and setting of the work, as in time-limited work, then the model would need to take account of these features. In this situation a very important part of the analyst/therapist's thinking would be how he/she

understands the meaning and function of working in a time-limited way, that is how working to a planned ending is very different to working in an open-ended way. An important part of the working model of the clinician working in a time-limited way would then be whether he/she sees this as a deficient or impoverished form of analysis/therapy, or as a way of working which has opportunities (particularly in how the explicit and fixed ending is managed by both patient and therapist) as well as limitations. In fact the meaning of the salient features of the setting for the analyst/therapist - that is the function and value attributed to session frequency, the use of the couch and other parameters - is, in my view, an important part of the working model of any analyst or therapist in all clinical situations.

My argument in this paper is that the Comparative Clinical Method has much to offer psychoanalytic psychotherapists in deepening their understanding of how they work. It may open the door to further questioning of how psychoanalysis might be really different or not from psychoanalytic psychotherapy, for example in this instance of how once weekly work might differ from work at a higher frequency. Do analysts/therapists who see their patients more times a week actually use different types of interventions, or similar interventions but for different purposes? Does one's working model change as one changes session frequency, as in those clinicians who claim to be able to work both as psychoanalysts and as psychoanalytic psychotherapists? I think our profession as a whole would benefit from using a method such as the one described in this paper to address such questions, so we can

better know what it is our fellow analysts and therapists actually do in their clinical work.

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